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https://dmas.virginia.gov
MEDICAID MEMO

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Implementation of the New Provider Remittances for Professionals and Facilities – November 5, 2004

The purpose of this memorandum is to communicate changes in the paper Facility Medical Remittance Advice (FN-O-053) and the Professional Medical Remittance Advice (FN-O-054). We are pleased to announce that, beginning November 5, 2004, provider remittances (RA) will reflect changes to the current formats and data content requested by providers since the implementation of the new Virginia Medicaid Management Information System on June 20, 2003.

The RAs have been re-designed with the assistance of a variety of statewide provider organizations. Many other organizations and individuals also provided assistance. The Department of Medical Assistance Services conducted statewide conference calls and provider meetings to solicit feedback for making the RA more user friendly and efficient. Many of these organizations' requests have been incorporated into the re-designed RA. The new RA format will feature:

n. No repetitious TPL information;

n. Line totals added by claim type: Subtotals are displayed between each section to ease balancing and posting. Facility claims include totals for number of claims, total charges, non-covered charges, and tentative contractual adjustments covered by program and net tentative reimbursement. Professional claims include totals for number of claims, billed amount, non-covered amount, covered by program deductible/coinsurance, copay/patient pay, primary carrier payment, and total payment;

n. Revised sort sequence: The new sequence is 1) claim type, 2) bill type,

and 3) payment status;

n. Page breaks to eliminate wasted space and to distinguish sections: A page break will be forced when the Claim Type or Payee ID changes. The financial summary of each payee will be printed on a new page;

n. Negative signs to indicate tentative contractual adjustments when the payment is greater than billed charges;

n. Negative signs to indicate credits and voids;

n. Contractual adjustments for outpatient revenue codes; and

n. Operational payment for psychiatric and rehabilitative hospital claims will be recorded in the DRG payment field.

Based on your provider type, an example of the applicable RA(s) is included as attachments to this memorandum.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 800-884-9730 or 800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its provider manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov (***please note the new DMAS website address***). Refer to the Provider Column to find Medicaid and SLH provider manuals or click on "Medicaid Memos to Providers" to view Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet, or would like a paper copy of a manual, you can order these by contacting Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long-distance
1-800-552-8627	All other areas (in-state long-distance, toll-free)

Please remember that the "HELPLINE" is for provider use only.